Chesapeake Health Department
PATIENT DISCHARGE QUESTIONNAIRE

PROGRAM:_____

We have been pleased to provide you with Home Care Services. Please take a moment to answer this questionnaire. Your answers will help us improve services.

1. Who referred you to the Health Department?
   Doctor____Hospital____Friend____Self/Family____Other____

2. What services were provided?
   Nursing____P.T.____O.T.____Nursing Assistant____Other____

3. Were instructions and/or treatments explained clearly and thoroughly? Yes___No___

4. Was the length of visit adequate? Yes____No____

5. Were you satisfied with personnel? Yes____No____
   If No, why not?_____
   _____

6. Was the service what you expected it to be? Yes____No____
   If No, how did it differ from what you expected?_____
   _____

7. When we ended our service to you, did you feel that patient/family needs were met?
   Yes____No____ If no, why not?_____
   _____

8. Would you use this service again? Yes ____No____

9. Would you recommend this service to others? Yes____No____

10. Were office personnel courteous and helpful to you on the phone? Yes___No___

11. Suggestions you would make to improve these services:_____
    _____
    _____
    _____
    _____
    _____
    _____

Signature (if desired):_____

Thank you for responding. Please return this questionnaire in the enclosed envelope.